Health care in the United States: The need for a new paradigm

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American medicine, as practiced at the close of the 20th century, has some major problems that we categorize as being "upside down, inside out and backward". Fortunately, these are correctable.

First, it is upside down. Primary care should be the foundation of the structure upon which the entire practice of medicine is built. However, it is not working that way. Specialists and subspecialists have become the wobbly foundation of health care in America. This makes our care system "upside down", with the underpinning being procedure-oriented specialists who get only a glimpse of whole patients and their needs.

That is not the only problem. The system is also "inside out". The key person in the entire system, and the whole reason for health care, is the patient. The patient has become lost within a very complex, disconnected system. The welfare of the patient should be the core that provides the energy that drives the system. Does it really work that way? Not quite. The patient, not necessarily his or her welfare, sometimes becomes the grist for the medical mill. The system is turned inside out.

And it is "backward". But how can we believe the American health care system, which has made such enormous strides in the last century, can be called backward? There is no argument regarding the high peaks of achievement in both research and practice; but there are deep valleys with a persistent and increasing percentage of the U.S. population (with the exception of Hawaii) that has no health insurance coverage. In addition to 30-million people without health insurance, there is a worsening of many of our vital statistics. Infant mortality is increasing as is mortality from many preventable diseases such as lung cancer. Patients, their physicians, the government and insurance carriers are all dissatisfied with our system. Are we moving forward or backward? The figures indicate that in many areas we are slipping backward.

How it was before WWII

Prior to World War II, 1941 to 1945, most physicians were engaged in Fee-for-service, private, general practice. With few exceptions, both patients and physicians were satisfied with their care. Physicians and patients negotiated a fee for whatever service was required—usually satisfactory to both. There was also an unwritten contract between the two and a written oath binding the physician. The unwritten contract was that the physician would do everything within his or her power to improve the health of the patient, and the patient agreed to do everything within his or her capability to cooperate in achieving the desired outcome. The written oath, of course, was The Oath of Hippocrates.

Medical students were introduced to medicine as being a sacred trust and were required to take the oath at a rather solemn ceremony. For more than 2,000 years this has been the code of ethics in the practice of medicine. The welfare of the patient was deemed to be of paramount importance and the patient was not to be exploited in any manner.

In the late 1930s the nation was just emerging from the Great Depression. Almost no one was wealthy and the cost of everything, including medical care, was of considerable concern. It was expected that every physician would spend at least a part of the day in the hospital or a full afternoon every week in the outpatient clinic caring for welfare patients termed the medically indigent. These patients were generally cared for in hospitals affiliated with university schools of medicine. In general, their care was excellent but the patients were denied what the rest of society had—the free choice of physicians.

Health insurance plans

There was increasing concern, even among the employed, that a catastrophic illness could wipe out a family's financial resources. To circumvent an individual or family being so devastated by illness, Blue Shield/Blue Cross Insurance plans made their appearance. In Hawaii, the HMSA insurance plan appeared shortly before WWII as a result of cooperative efforts by school teachers, social workers and physicians. Physicians had no great objection to this arrangement because they would still be paid pre-determined, adequate compensation for specific services.

On the surface this seemed to be a good arrangement. Cost of medical care was distributed over groups of people and periods of time. There were, however, persisting major disadvantages to this arrangement. First of all, it handsomely rewarded physicians for doing "something" to the patient whether or not the "something", in the form of a test or operation, made any difference in the ultimate outcome. This was accepted and easy to rationalize because an x-ray of the chest or removal of a gallbladder could be documented and priced.

In contrast, however, it was very difficult to document and to put a price tag on a physician's conviction that a patient did not need an x-ray or cholecystectomy. It is virtually impossible to arrive at a fee schedule for successfully getting a patient to stop smoking and thus avoiding not only cancer of the lung, the most common fatal cancer of both sexes, but possibly eliminating over $100,000 worth of surgery, countless costly diagnostic procedures, chemotherapy, prolonged hospitalization and premature death.

The introduction of medical insurance also had the drawback of moving the patient out of the decision-making loop once he or she had decided on the specific insurance carrier and type of policy. The unwritten contract between patient and physician now includes a third party and a written contract with the insurance carrier that binds both physician and patient, as well as hospitals. Need it be added that there has been a continuing difference of opinion between hospitals, physicians as suppliers of services, and insurance payers for services, as to what is a proper financial arrangement? If the insurance carrier agrees to the fee increases for suppliers of services, it is reflected as an increase in the next year's insurance premium paid by patients or their employers. If the

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carrier doesn't agree to an increase, the battle goes on. The insurance system does not cover the uninsurable, nor does it cover preventive services.

The capitation plan

As the United States entered into WWII, a red-haired young physician who had previously worked with industrialist Henry Kaiser by furnishing medical care to his construction workers was asked to develop a plan for Kaiser workers who were building liberty ships in Richmond, California. Sidney Garfield MD agreed to develop the Kaiser-Permanente Health Plan that blended a not-for-profit health plan, including hospital and outpatient facilities, with a for-profit group of physicians. Medical care was paid for by capitation rather than on the Fee-for-service basis (from the Latin *capit* or head tax). The difference was that providers of care were paid per enrolled individual regardless of the presence or absence of sickness, diagnostic tests performed, or operations undertaken. All in all this has worked well, largely because of the organizational genius, professional competency and pioneering efforts of the founding half-dozen physicians, including Sidney Garfield, Morris Collen, Cecil Cutting (the brother of the first dean of the UH School of Medicine) and several others. It is, in our opinion, an improvement over the Fee-for-service system in that it has the potential for encouraging efforts and rewards for promoting and maintaining good health, as well as preventing disease, which is as yet only partially realized otherwise.

Adding to the pool of players in the U.S. health care system—patients, providers and payers—in 1965, the Federal Government entered as an important player by introducing Medicare and Medicaid, designed to care for the elderly and the poor respectively by funds obtained through taxes.

The biomedical model

During this same time frame, when efforts were being made to distribute the cost and availability of health care more equitably, an unprecedented surge of achievement in basic biology and medicine took place. Within this bio-medical framework, hearts were being transplanted, damaged joints replaced, previously fatal diseases including certain types of cancers were being cured or controlled. Smallpox was eliminated and poliomyelitis became preventable. Genes that determine who we are, how we function, and to a great degree the diseases that we may get are being decoded, spliced and replaced. Paralleling this biomedical research and health care achievement, medical care became centered on specific organs, disease, and technical interventions. General practice, oriented to care for the whole patient, gave way to specialist care designed to care for diseased organs. Although history may recognize the last half of the 20th century as the Golden Era of Medicine, if this be true, not many people are overly happy about it.

Discontent

Almost half of all physicians over age 40 or who have been in the practice of medicine for at least a decade state they would not choose medicine as a career if they had to make the decision again. This incidentally is in contrast to what attorneys state: Only 15% would pick a career other than law (we suspect there may be a relationship between attorneys' contentment and physicians' discontent!).

Businesses, both large and small, are unhappy, particularly about the cost of medical benefits for their employees and recently have expressed concern that the quality doesn't match the cost. Large companies, such as the automotive industry, indicate part of their problem in competing with foreign automakers is the cost of medical care in the U.S. Smaller companies, which sometimes employ many more workers than do the large ones, are strongly protesting the shift in policies that require them not only to pay for the medical care of their employees but also to pay someone to look after the increasing government paperwork that is required.

Hospitals have become extremely unhappy about the decreasing level of reimbursements, often unpaid-for services, and greater competition. There has occurred a resultant bankruptcy of a large number of American hospitals over the past few years. Insurance carriers are unhappy at being constantly caught in the squeeze between enrollees who on one hand expect the best and most expensive care possible as long as someone else pays for it and on the other hand become very upset as premiums increase.

Most important of all, patients are not happy with their health care. They may be satisfied with their personal physician but not with the overall system. Many have been led to believe that good health can be bought. The message has been: "Don't worry too much about what or how much you smoke, eat or drink; if the arteries of the heart get clogged or the lung cells turn to cancer, treatment is available". It is much more financially rewarding for all members of the supply-side of care to diagnose and treat the results of unhealthy life-styles than to spend the time and effort to assist in the development of more healthy life-styles or to modify unhealthy life-styles beneficially.

The federal government, composed of those trusted public servants who congregate in Washington, flush with victories in improving education, reducing drug-related problems, assisting in providing housing for the homeless and regulating savings and loan agencies, has seized the opportunity to turn public concern into a matter of personal job security. As with many of government's well-meaning efforts, nationalization of health care will contribute more to the problem than to the solution. The federal government has, through its control of Medicare and Medicaid funds, become a major force in preventing needed innovations in health care. The government achieves this through rigid guidelines and regulation, requiring massive paperwork. Jack Lewin MD, the director of the Hawaii Department of Health, who has spearheaded much of Hawaii's efforts to provide all residents with health care, can attest to this—as can every practicing physician in the nation. Paradoxically, the same national politicians who created these restrictive laws and regulations are the most strident voices calling for health care reform and national health insurance. None has suggested the proper, needed changes in design and structure.

If everyone involved is unhappy with the health care system, chances are there is a problem. There is no denying the problem is a complex mix of poor distribution of care, with millions of Americans uninsured, and cost of care running about 12% of the GNP; this is in contrast to that of Canada and other emerged nations where it is in the neighborhood of 8%. This year members of the U.S. Congress held public meetings throughout the country to hear the people voice their concerns about health care that is largely focused on which of 5 plans for national health insurance they

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preferred—all of which have as a major goal the control of costs rather than restructuring the system.

Faulty assumptions

To no one's great surprise, many people suggested cost was the problem and national health insurance the cure. In Hawaii, Governor Waihee appointed a blue-ribbon panel on health care in 1991 to address the problem of the high cost of health care in Hawaii. A report was to have been made in January 1992 and was recently released.

Most efforts to improve the ailing health care system are based on 3 assumptions—all wrong:

1) The cost of health care is the cause of the problems;

2) redistributing the cost and the remuneration for giving care will provide the leverage to bring about needed reforms and result in more equitable care;

3) medical and political policy experts have the knowledge and wisdom to solve the personal health problem of individuals.

Consequence, or cause?

The increase in cost of medical care is the result of a badly designed and poorly constructed system. The latter's poor design and function includes inappropriate and wasteful use of resources, excessive government bureaucracy and needless procedures done to prevent or reduce outlandish malpractice awards. It also costs too much because of stifling barriers to creating solutions. Since it became apparent that Medicare and Medicaid were costing far more than anyone anticipated and actually are contributing to the high cost of health care, there has been an almost unending tinkering with the financial aspects of care, usually masquerading as an effort to improve quality.

Redistributing the financial rewards for providers of care has not solved this complex puzzle. Diagnosis-Related Groups (DRGs) and Resource-Based Relative Value Scale (RBRVS) are the most recent federal attempts to solve the health care problem by financial tinkering.

The DRGs provide a means of payment to hospitals on the basis of predetermined dollars according to the diagnosis. The theory is that excessive hospital costs will be reduced by limiting the days the patient stays in the hospital and curtailing unnecessary tests and procedures.

The RBRVS pays for physician services based on years spent in training, the complexity of the medical problem and the degree of skill required in its resolution. These are massive programs covering all Medicare and Medicaid patients and will probably be expanded to cover all privately insured patients. They will neither provide for, encourage, nor even permit the necessary restructuring of care (both DRGs and RBRVS will eventually fail).

Insurance plans have flattened out the economic peaks and valleys in health care, which is desirable. The Kaiser-Permanente capitation plan has the proper foundation to build the structure in which there are greater rewards—financial and other—in keeping patients healthy. This includes keeping them out of doctors' offices and hospitals, with the opportunity to enjoy a happy functioning family, productive work and the realization that they are helping to preserve a peaceful, desirable environment for future generations. This hasn't happened yet in Kaiser-Permanente or any other health care plan, partly because doctors and nurses have jumped through the same hoops in their professional training as their cohorts practicing in other settings. They are operating within the confines of the same biomedical paradigm as the rest of us and are kept exceedingly busy—caring for the health problems as defined within this paradigm.

The third incorrect assumption is probably the most to be feared of all 3. No expert is knowledgeable enough or wise enough to make decisions for the health and welfare of another, adequately informed, rational adult, and many children. Every person has the right and responsibility to make his or her own decision about personal health.

All of the foregoing indicate that past, present, and most future plans for improving health care have not and will not work within a care system largely limited to the specialist, Fee-for-service, biomedical model. It may be that we need to look at a different way of conducting health care.

Responsibility

Both individuals and communities must become more involved in their health. First of all, those who are to be cared for within the system must be encouraged and permitted to define their individual as well as collective needs. An informed individual is in the best position to make decisions regarding his or her well-being. Only recently has it been recognized and accepted that personal life-style has considerable influence on an individual's health. We were very slow to appreciate that substance abuse in the form of calories, alcohol, drugs, tobacco, and physical inactivity account for most premature morbidity and mortality.

We are only beginning to think about a community's responsibility for its own health. We have scarcely started to address community diseases of multifactorial causes. These diseases involve members of the community who are homeless, jobless, poorly educated, mentally dysfunctional, poorly nourished, financially poor and without hope; they are frustrated and angry. It also includes those who exhibit irrational, destructive violence. If health care has a goal of reducing morbidity and mortality, it must recognize the foregoing as health issues. The most common cause of death in young black men is a "disease" caused by a gun or knife. Communities must become involved in diagnosing and treating health problems as defined by the community itself. This mechanism whereby a community defines its collective needs and individuals define their individual needs must be a dynamic process to address properly the constantly changing needs in an equally constantly changing health care environment. Both individuals and communities have the shared responsibility of differentiating appropriate needs from inappropriate desires and matching needs to finite health care resources.

A new type of physician, a generalist in contrast to a specialist, must be created to practice medicine in a vastly different way from his or her predecessors. He or she must perceive individuals and the collection of individuals who make up a community as his or her responsibility in a different manner. This physician must also acquire the tools and methods to meet this responsibility. This does not mean a break with the traditional values of medicine as a sacred trust, which puts paramount value on promoting the well-being of the patient. It does mean that to serve individuals and communities adequately as a generalist, scientific knowledge and art applicable to resolving community health problems as well as

individual health problems must be used. These include the tools of epidemiology, biostatistics, informatics, decision analysis, outcomes research, economics, social psychology, cultural anthropology and demography. Awareness of the social, environmental and psychological influences on health care, combined with the new tools described, will contribute to the creation of a more rational model of health care.

The biomedical model has been the framework for outstanding advances in medicine over the past century. We are not advocating that it be abandoned. Neither are we advocating that specialist care be abandoned. However, our model must include the social, environmental and psychological factors that play a much more important role on health than previously appreciated—a biomedical-psychosocial model. This generalist physician functioning within this model will require an intellectual foundation involving all social and scientific disciplines. Colleges of health sciences, and particularly schools of medicine, must revamp their curricula and move more of their teaching out of academic ivory towers and hospitals and into community health centers and other community facilities. When a change of this magnitude is made, all elements of the system must change. This includes everything from changing responsibilities of physicians, nurses, health aides, technicians and administrators. It also will require change in fiscal arrangements, facility design, data management, research and teaching activities, to name a few.

The contrast

We propose contrasting the generalist—a community-oriented, capitation-paid, biomedical/psychosocial-model physician—to the specialist—the hospital-oriented, Fee-for-service, biomedical model. In this new model of health care, the generalist will play a key role. The present generalist is underrepresented (30% of the total number of physicians in the U.S.), overworked, and for the greater part, underpaid. In Hawaii we do better, with 52% of physicians being generalists. Fifty-one percent of medical students graduating from the UH John A Burns School of Medicine in the past 3 years—1990, 1991 and 1992—have selected residency training that will prepare them as generalists. Nationwide the percentage will have to almost double over the next decade, with a corresponding reduction in specialists. Specialists must remain in the system but must be utilized more appropriately.

Emphasis on locus of care must shift increasingly from hospital-oriented care to community-oriented health centers. The method of paying for health care also needs to shift from the Fee-for-service system that thrives on sickness, costly procedures, overspecialization and neglect of preventive efforts to a capitation system that has more positive incentives to keep people healthy with more judicious use of costly high-tech interventions.

The biomedical model presently utilized in medical teaching, research and services is not to be abandoned but must be modified and broadened to include the broader social, economic and other factors that influence health and disease. The present model needs to be expanded into the biomedical/psychosocial model.

Physicians, nurses, allied health personnel and others would have newly defined jobs with increased emphasis on preventive care and health promotion. Computerized medical records would provide the data bases needed for both individual and community health risks and problems. The data generated would also provide the capability to determine the relationships between decisions made, actions taken, and eventual outcomes. Decision analyses and outcomes research centering on cost and effectiveness of various types of interventions and noninterventions would provide more accurate information available to physicians, patients and communities to benefit their collaborative efforts regarding health. Decisions made and actions taken would be driven by hard data, most of which is lacking within our present care system. Students in medicine, nursing, public health and social work would share learning experiences gleaned from dealing with health problems and their solutions from a new perspective within a different paradigm.

Hawaii has had considerable success with some elements of the health system that we have just described. The plantation health care system was a community-oriented capitation system staffed by generalists. It was by far the best rural health care system that existed in its time. The lessons learned from the plantation system continue to influence health care in Hawaii.

Hawaii has a legitimate right to be called *The Health State*. Its citizens live longer and have fewer preventable deaths than any other state in the U.S.

Almost all of its people are covered by health insurance. The cost of health care is probably the lowest in the nation, consuming only 8% of its "GNP" as compared to the rest of the nation's 12%.

With continued improvement in health care in Hawaii, the system can be made right side up, inside in and moving forward. The rest of the United States might well profit from our experience.

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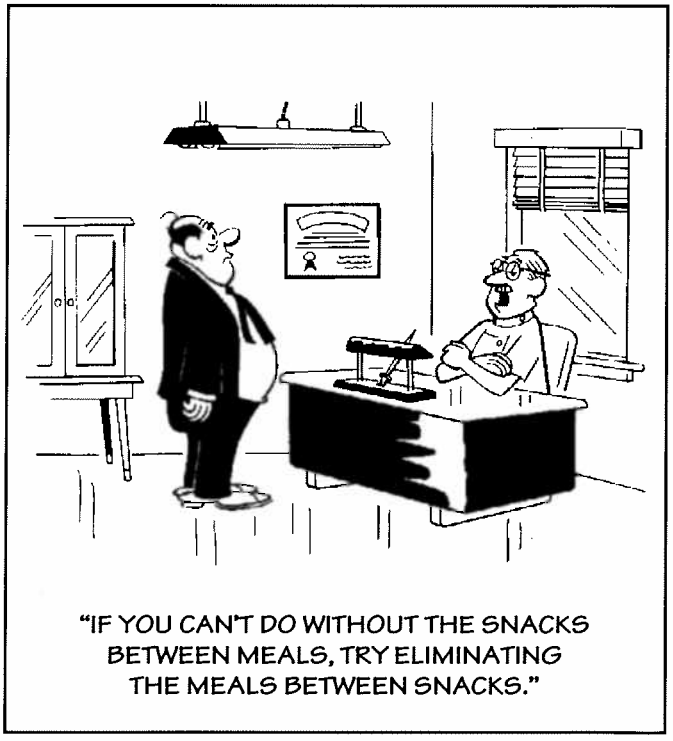

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